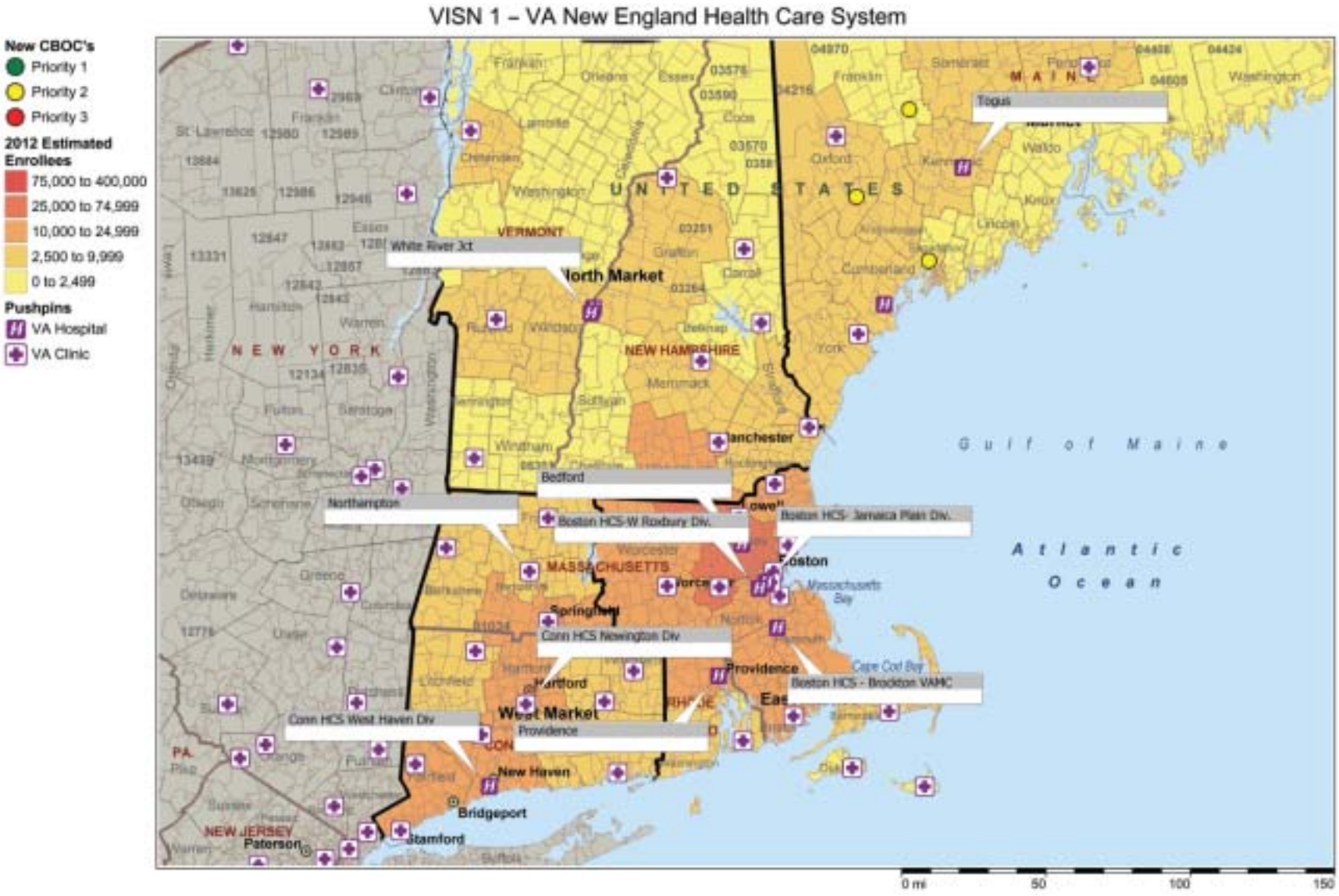

VISN 1, VA New England Health Care System

VISN Overview

VISN 1, VA New England Health Care System, is an integrated, comprehensive health care system that provided medical services to approximately 206,000 of the 325,000 veterans enrolled in VA's health care system in FY 2003.[3] Geographically, this VISN spans about 68,700 square miles and consists of the six New England states of Maine, New Hampshire, Vermont, Massachusetts, Rhode Island, and Connecticut. It includes a total veteran population of 1.2 million.

With a VA staff of 8,892 FTEs,[4] VISN 1 delivers health care services through eight medical centers, 38 community-based outpatient clinics (CBOCs), six nursing homes, and two domiciliary care facilities. Additionally, VA operates 18 veterans outreach counseling centers (hereinafter referred to as Vet Centers) in VISN 1's catchment area.

The following table indicates actual enrollment figures for FY 2001. Figures for enrollment in FY 2012 and FY 2022 are based on the latest CARES Scenario Milliman USA projections and represent end-of-year projections. Figures for veteran population come from the latest VetPop2001 model. These data were used by the Draft National CARES Plan (DNCP) to identify the levels of need for services in VISN 1.

VISN 1	FY 2001	FY 2012	FY 2022
Enrollees	280,850	281,126	232,102
Veteran Population	1,281,914	935,188	686,577
Market Penetration	21.91%	30.06%	33.81%

This VISN consists of four markets: the Far North Market (*facility:* Togus, ME); the North Market (*facilities:* White River Junction, VT, and Manchester, NH); the West Market (*facilities:* West Haven and Newington, CT, and Northampton, MA); and the East Market (*facilities:* Bedford, MA; Providence, RI; and Brockton, Jamaica Plain, and West Roxbury, MA).

[3] VSSC KLF Menu Database, *Enrollment Priority and Status by Gender*, as of the end of FY 2003.
[4] VSSC KLF Menu Database, *FMS Annual Salary Report*, FY 2003: July 2002 through September 2003.

Information Gathering

The Commission visited seven sites in VISN 1 and conducted one public hearing. The Commission received 15,602 public comments regarding VISN 1.

- *Site Visits:* Bedford, Brockton, and West Roxbury on July 8; Bedford, Brockton, and West Roxbury medical centers, the VA Causeway Outpatient Clinic, and the Jamaica Plain campus in Boston, MA, and the Providence, RI, and Manchester, NH, medical centers on September 15 and 16.
- *Hearing:* Billerica, MA, on August 25.

Summary of CARES Commission Recommendations

I Mission Change, Campus Realignment – Edith Nourse Rogers Memorial VA Medical Center in Bedford

1. The Commission does not concur with the DNCP proposal to change the mission of the Bedford VA Medical Center (VAMC).
2. The Commission recommends that VA conduct a thorough feasibility study of building a single, appropriately sized replacement medical center in the Boston area for acute and sub-acute inpatient services, residential rehabilitation services, and administrative and research support. This medical center would replace all such existing functions at the West Roxbury, Jamaica Plain, and Brockton campuses of the Boston Health Care System (HCS) and the Bedford VAMC.
3. As part of the planning for a possible replacement medical center in the Boston area, the Commission recommends that:
   a. The VISN develop a strategic plan to determine the appropriate size and location for coordinated long-term care (LTC) services, including nursing home care and the Geriatric Research, Education and Clinical Center (GRECC) clinical and research services that are integrated with them, and ensure there is no loss of capacity and specialty programs.
   b. Prior to taking any action to reconfigure or expand LTC capacity or replace existing LTC facilities, VA should develop a LTC strategic plan. This plan should be based on well-articulated policies, address access to services, and integrate planning for the LTC of the seriously mentally ill.[5]
   c. An integral part of the strategic plan should be maximizing the use of State Veterans Homes.
   d. Domiciliary care programs should be located as close as feasible to the population they serve.

[5] Chapter 3, *National Crosscutting Recommendations: Long-Term Care,* contains additional information on this topic.

e Freestanding LTC facilities should be permitted as an acceptable care model.

4 The Commission concurs with the DNCP proposal for a feasibility study for the Jamaica Plain campus and recommends that it be done in conjunction with the feasibility study of a single replacement medical center in the Boston area.

(see page 5-9)

II Inpatient Care

1 The Commission concurs with the DNCP proposal to use contracting to improve access for hospital care in the North and Far North markets, and to pursue telemedicine opportunities.

2 The Commission recommends that VA ensure that it has quality criteria and procedures for contracting and monitoring service delivery, as well as the availability of trained staff to negotiate cost-effective contracts.

3 The Commission concurs with the DNCP proposal to meet increasing inpatient demand in the East and West markets through in-house expansions at Providence and West Haven. Expansion at West Roxbury should be considered as part of the feasibility study for a replacement facility for Boston.

(see page 5-15)

III Outpatient Care

1 The Commission recommends that:[6]

a The Secretary and USH utilize their authority to establish new CBOCs within the VHA medical appropriations without regard to the three priority groups for CBOCs outlined in the DNCP.

b VISNs set priorities for the establishment of new CBOCs based on VISN needs to improve access and respond to increases in workload.

c VISNs should be able to address capacity issues, to relieve space deficits at the parent facility, by establishing new sites of care, provided the VISNs have the resources necessary to do so.

d VISNs make efficient use of existing resources, including staffing facilities appropriately to reduce wait times, providing specialty care at CBOCs where appropriate, and providing expanded hours of service at CBOCs to facilitate veteran access to care.

[6] Chapter 3, *National Crosscutting Recommendations: Community-Based Outpatient Clinics (CBOCs)*, contains additional information on this topic.

e Whenever feasible, CBOCs provide basic mental health services.

f VISNs collaborate with academic affiliates to develop learning opportunities utilizing CBOCs as teaching sites to enhance quality of care in community-based service settings.

2 The Commission concurs with the DNCP proposal to use telemedicine programs at existing sites of care and at proposed new CBOCs to help address access issues.

3 The Commission recommends that VA ensure that it has quality criteria and procedures for contracting and monitoring service delivery, as well as the availability of trained staff to negotiate cost-effective contracts.

(see page 5-17)

IV Extended Care

1 The Commission recommends that:[7]

a Prior to taking any action to reconfigure or expand LTC capacity or replace existing LTC facilities VA should develop a LTC strategic plan. This plan should be based on well-articulated policies, address access to services, and integrate planning for the LTC of the seriously mentally ill.

b An integral part of the strategic plan should be maximizing the use of State Veterans Homes.

c Domiciliary care programs should be located as close as feasible to the population they serve.

d Freestanding LTC facilities should be permitted as an acceptable care model.

(see page 5-20)

[7] Chapter 3, *National Crosscutting Recommendations: Long-Term Care,* contains additional information on this topic.

Mission Change, Campus Realignment – Edith Nourse Rogers Memorial VA Medical Center in Bedford

DNCP Proposals

"*Bedford* – Outpatient services will be maintained at the Bedford campus. Current services of inpatient psychiatry, domiciliary, nursing home, and other workload from the Bedford campus will be transferred to Brockton, West Roxbury, and other appropriate campuses (Manchester). The remainder of the Bedford campus will be evaluated for alternative uses to benefit veterans such as enhanced use leasing for an assisted living facility. Any revenues or in-kind services will remain in the VISN to invest in services for veterans. *Jamaica Plain* – Study the feasibility of designing the Jamaica Plain campus to consolidate services into building for operational savings and to maximize the enhanced use lease (EUL) potential of the campus for assisted living or other compatible types of use. Retain multidisciplinary outpatient clinic."

DNCP Alternatives

1. *Status quo*
2. *Original Market Plan:* Retain inpatient capacity at Bedford.
3. *100 Percent Contracting*
4. *Alternative 1 [The VISN's preferred alternative]:* Transfer 75 inpatient psychiatry beds, 40 domiciliary beds, 240 nursing home beds, minimal amount primary care, and mental health care workload and research associated with inpatient programs to Brockton. Transfer 30 nursing home beds to Manchester. This option reflects a reduction of approximately $838 million compared to the status quo.
5. *Alternative 2:* Consolidate all inpatient and outpatient programs from both the Bedford facility and the VA Boston Health Care System (Brockton, Jamaica Plain, and West Roxbury campuses) to one large replacement medical complex located in Boston.

Commission Analysis

At the time of the initial site visit to the Boston area medical facilities in July 2003, including the Bedford facility, the DNCP proposal for the Bedford facility was uncertain. The visit revealed that many facilities, including Brockton, which would receive some of Bedford's inpatient services, were in need of renovations to improve patient areas. The buildings are aesthetically unappealing and the mechanical infrastructures, such as air conditioners in several of the buildings toured, were malfunctioning. In spite of this, on the day of the visit to the Bedford nursing home and Alzheimer's unit, Commissioners observed many family

members involved in the ongoing care of patients. These observations support maintaining Bedford's long-term care operations. Proximity and quality of care allow the families immediate access to loved ones and relocating patients to another facility would not only disrupt the family connection, but might mean disruption of the family's ability to assist in the veteran's care. As one family member wrote, "We chose Bedford due to its proximity to our family (especially my mom). Dealing with my dad having Alzheimer's disease has been an excruciating time in my life. If you care to visit the facility any day at noontime, you will see many of the veterans' wives and/or children there feeding their loved ones lunch. I make it a habit of spending one or two lunchtimes a week there."[8]

The hearing record also indicated that a change in Bedford's mission would negatively impact research on Alzheimer's disease and psychiatry, as well as the medical education of medical students and residents. As Dr. Aram V. Chobanian, Dean of Boston University's School of Medicine and Provost of the Boston University Medical Campus, testified:

> I also have serious concerns about the potential impact of the proposed National CARES Plan on Bedford's nationally recognized Center of Excellence in Alzheimer's disease. The current program integrates the inpatient activities with those involved in ambulatory care, adult day care, hospice care, and research. Many of the clinical and research staff work on several of these components and moving part of the program some 35 miles away would create serious logistic issues for this outstanding center.[9]

In response to the hearing, the Commission determined that further study of the proposal was required. This included additional analysis of data and a second, more comprehensive site visit, this time to all Boston area facilities, and also to the VAMCs in Manchester, NH, and Providence, RI.

On the follow-up site visit to VISN 1, a special consultant on hospital construction and renovation with extensive experience both in VA and the private sector accompanied Commission members. The Commissioners and consultant concurred that all four major campuses in the Boston area are in need of significant construction to improve medical and patient areas, to meet infrastructure requirements (including mechanical, privacy, and safety), and to enhance the aesthetic value of the buildings. Inpatient areas at West Roxbury are very congested, space is cramped, and the older construction does not provide adequate ceiling height and is not configured to accommodate new technologies. This requires additional staff time and effort to maintain the quality of care and results in inefficiencies and an unattractive environment of care for patients and staff. Acute and intermediate psychiatry as well as residential rehabilitation areas at Brockton and Bedford are aging. The spinal cord injury (SCI) unit at Brockton particularly is below accepted standards.

---

[8] Meg Anderson, Written Public Comment submitted on VISN 1.

[9] Aram V. Chobanian, MD, Dean, Boston University School of Medicine, Boston, MA. Transcribed Testimony from the Bedford, MA, Hearing on August 25, 2003, page 171.

The VHA Office of Facility Management Facility Condition Database indicates that the "correction costs" necessary to upgrade the four Boston area campuses exceeds $300 million.[10] For VA to be a competitive employment option in the Boston area, which is known for its modern health care with state-of-the art medical facilities and technologies, and its strong, prominent academic institutions that attract extraordinarily skilled professionals, it would need to upgrade the infrastructure of its Boston area facilities.

Services provided in the greater Boston area are dispersed among four sites. An average daily census (ADC) of approximately 75 acute medical beds, 35 surgical beds, and 20 intermediate care beds are sited at the West Roxbury campus. Spinal cord injury beds are split between the West Roxbury (ADC 19) and Brockton (ADC 24) campuses. Acute psychiatry beds are divided between the Brockton (ADC 51) and Bedford (ADC 10) campuses. Sub-acute psychiatry beds are split between Brockton (ADC 64) and Bedford (ADC 50). Residential rehabilitation beds (psychiatric residential rehabilitation treatment program [PRRTP] and domiciliary) are split between the Brockton and Jamaica Plain campuses (with combined ADC 71) and Bedford (ADC 89). Nursing home care beds are divided between Brockton (ADC 124) and Bedford (ADC 256).[11] Outpatient services also are offered at numerous sites including the West Roxbury, Jamaica Plain, Brockton, Bedford campuses, at a large outpatient clinic in downtown Boston (Causeway Clinic), and in area CBOCs.

Travel between these geographically dispersed sites of care is generally through congested Boston city streets. Thus, access to care is less than optimal due to the dispersion of services and the locations of the current sites of care. Furthermore, acute psychiatry services, including substance abuse detoxification, are on different campuses than are acute medical services, though the Commission heard in repeated testimony across the country that quality of care is enhanced when acute psychiatry and acute medical services are on the same campus. Acute psychiatry services are also best located in close proximity to intermediate psychiatric care. The separation of the acute and longer-term SCI units limits the flexibility of the SCI staff in caring for patients.

Operating on four campuses in the Boston area, the VISN must maintain a large amount of acreage and a number of aging buildings, including the large, former main hospital building at Jamaica Plain. This requires large expenditures for maintenance personnel and for recurring maintenance projects and utilities. The widespread dispersion of staff and services also results in inflated transportation costs and lost time for staff traveling between campuses. Old space originally configured for inpatient services at the Jamaica Plain campus is being used for outpatient care, to house research centers, and for administrative functions, which is inefficient and wasteful.

[10] VISN 1, October 22, 2003 Response to the September 22, 2003 *Realignment Analysis Requirement Data Call Memo.*
[11] VSSC KLF Menu Database, *Workload from AMIS Report*, as of the end of FY 2003.

However, when following the hearing in Boston, the VISN was required to conduct a cost benefit analysis to compare the long-term cost of various alternatives,[12] these costs did not seem to be considered. Though the VISN's alternatives included constructing a 600-bed replacement medical center at a cost of $609 million, the VISN did not recommend this alternative. Instead, the VISN recommended transferring Bedford's inpatient services to Brockton and Manchester, with estimated renovation and construction costs for the four Boston facilities at $57.3 million and for Manchester at $150.2 million.

The VISN cost analysis for a replacement facility was counterintuitive in that the life cycle costs presented were higher than the recommended alternative by $2.3 billion. In the realignment proposal study, the VISN estimated that life cycle recurring costs for staffing and maintaining a newly constructed facility would exceed the life cycle cost of maintaining the current dispersed aging facilities. This is inconsistent with past experiences in VA and with other proposed mergers of campuses in the DNCP, which invariably project substantial savings in operating costs from the merger of campuses into new construction. These savings should include:

- Substantial savings in the approximately $38 million spent annually on buildings and ground maintenance for the current aging campuses with large numbers of buildings and acreage.
- Savings in other administrative overhead costs from the merger of the Bedford and Boston HCS leadership offices, from reduced security needs for a single campus; from the further merger of other administrative services such as human resources, medical administration, acquisition and fiscal; and from efficiencies in transportation costs and lost time due to staff travel.
- Savings in clinical costs, for example, clinical after-hours' supervision should be more efficient, and savings should accrue from more modern, well-organized clinical space.

Review of the cost benefit analysis suggests no projected appreciable operational savings from transferring services to the newly constructed hospital. This is despite a statement in the narrative portion of the analysis that indicates, "Provision of inpatient and outpatient care at a modern facility located on a single site would significantly improve staff and operational efficiencies by offering 'one stop care for veterans'. ... Duplication of services/equipment between campuses would be eliminated. Bedford, Brockton, Jamaica Plain and West Roxbury campuses could be sold to offset the cost of constructing a replacement facility."[13]

The Commission, based on hearing testimony and personal observations at the site visits, noted that nursing home services need to be well better distributed across the Boston area to ensure that there is adequate access for patients and their families, who need the opportunity to be involved in the patients' ongoing care. The Bedford facility has recently completed significant renovations at its nursing home and is currently in

[12] VISN 1, October 22, 2003 Response to the September 22, 2003 *Realignment Analysis Requirement Data Call Memo.*
[13] VISN 1, October 22, 2003 Response to the September 22, 2003 *Realignment Analysis Requirement Data Call Memo.*

the process of making additional renovations to make the nursing home unit a state-of-the-art treatment center. In addition to improving the infrastructure for patient care services, it would appear that the capital improvements might be a step toward improving the facility's aesthetic quality. To abandon these capital investments would not appear to be reasonable or cost effective and would move away from improving VA's competitive edge in the employment arena.

Commission Findings

1. Quality of care and access for families of LTC and nursing home patients at Bedford would not improve under the VISN's preferred alternative.
2. Nearly 15,500 public comments were received that favored maintaining Bedford's LTC operations.
3. Affiliate relationships may suffer under the DNCP plan for Bedford.
4. The Boston area is known for its modern health care with state-of-the-art medical facilities and technologies and strong, prominent academic institutions. It is a highly competitive employment area for medical professionals. For VA to compete, it needs to upgrade the infrastructure of its Boston area facilities.
5. Site visit observations, including those from a special consultant on hospital construction and renovation, indicate that virtually every Boston area facility requires renovations to improve medical and patient areas to meet infrastructure requirements (including mechanical, privacy, and safety) and to enhance the aesthetic values of the buildings.
6. Acute and sub-acute inpatient care is currently fragmented and dispersed in the Boston area on multiple, aging campuses, leading to less than optimal access, coordination of care, and staff efficiencies.
7. Consolidation of services into a newly constructed, centrally located facility would correct deficiencies in the environment of care, improve staff efficiency, improve access to care, and increase coordination of care.
8. The cost benefit analysis comparing the cost of maintaining the current facilities versus building a new single facility contains inconsistencies.
9. There is a high probability that a well-conceived plan to consolidate all acute and sub-acute inpatient services, many outpatient services, administrative functions, research functions, residential rehabilitation services, and a portion of the LTC services onto a single, modern

campus would improve the quality and coordination of care, improve access for most users in the Boston area, and increase efficiencies.

Commission Recommendations

1. The Commission does not concur with the DNCP proposal to change the mission of the Bedford VAMC.
2. The Commission recommends that VA conduct a thorough feasibility study of building a single, appropriately sized replacement medical center in the Boston area for acute and sub-acute inpatient services, residential rehabilitation services, and administrative and research support. This medical center would replace all such existing functions at the West Roxbury, Jamaica Plain, and Brockton campuses of the Boston HCS and the Bedford VAMC.
3. As part of the planning for a possible replacement medical center in the Boston area, the Commission recommends that:
    a. The VISN develop a strategic plan to determine the appropriate size and location for coordinated LTC services, including nursing home care and the Geriatric Research, Education and Clinical Center (GRECC) clinical and research services that are integrated with them, and ensure there is no loss of capacity and specialty programs.
    b. Prior to taking any action to reconfigure or expand LTC capacity or replace existing LTC facilities VA should develop a LTC strategic plan. This plan should be based on well-articulated policies, address access to services, and integrate planning for the LTC of the seriously mentally ill.[14]
    c. An integral part of the strategic plan should be maximizing the use of State Veterans Homes.
    d. Domiciliary care programs should be located as close as feasible to the population they serve.
    e. Freestanding LTC facilities should be permitted as an acceptable care model.
4. The Commission concurs with the DNCP proposal for a feasibility study for the Jamaica Plain campus and recommends that it be done in conjunction with the feasibility study of a single replacement medical center in the Boston area.

[14] Chapter 3, *National Crosscutting Recommendations: Long-Term Care,* contains additional information on this topic.

II Inpatient Care

DNCP Proposals

"*Hospital Care/Access* – Access in the North and Far North markets is being met through community contracts. In addition, telemedicine and telecare programs will be used across the VISN to improve quality and access for primary care and specialty care. The Maine Telemedicine program for the private sector will be used to provide cost-effective care to the Maine veterans in collaboration with the VA. *Medicine/Inpatient Services* – Increasing inpatient medicine demand and access gaps in the Far North and North markets is being met through community contracts, also needed to resolve access gaps. Increasing inpatient medicine demand in the East and West markets is being met through in-house expansion at West Roxbury, Providence, and West Haven. *Psychiatry* – Decreasing inpatient psychiatry demand in the East market is being met through the consolidation of acute psychiatry at Bedford, Brockton, and Providence."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

In the Far North and North Markets, less than 60 percent of enrolled veterans are currently within the VA's access standards for hospital care. The CARES standard is 60 minutes for urban areas; 90 minutes in rural areas; and 120 minutes in highly rural areas. Inpatient medicine workload is projected to increase in all markets by at least 70 percent over the FY 2001 baseline by FY 2012, and remain at least 26 percent over baseline by FY 2022. The Far North Market has the largest projected increase, with 209 percent over baseline by FY 2012, declining to 151 percent over baseline by FY 2022.[15]

CARES space management reports indicate space deficits for inpatient service areas at West Haven and Newington (West Market), West Roxbury and Providence (East Market), and Manchester (North Market). In-house expansions and improvements are the recommended remedies for access and workload gaps. As noted during discussions with VISN leadership and as observed at the specific facilities visited during Commission site visits, improvements are needed for inpatient care areas in every VA medical center in VISN 1 in order to respond to both access and workload gaps.

The DNCP recommends expanding inpatient areas at the Togus VA Medical Center (Far North Market), the only VA medical center in Maine, to respond to growing demand for inpatient services. In order to

[15] Appendix D, *Data Tables*, page D-1.

do this, however, Togus needs to reclaim the facility's inpatient areas by moving some outpatient services out of the medical center and into satellite locations. Once this has been done, the inpatient areas would undergo renovations. At the same time, the relocated outpatient services would be able to expand to include mental health services and specialty care, where appropriate. Additionally, at meetings with VISN leadership during the site visits, the Commission learned that the state of Maine has integrated a statewide telemedicine program to serve the medical needs of the general population. Leadership at the Togus VAMC has engaged the state leadership in developing a partnership whereby VA may use the telemedicine capabilities presently in place in Maine to serve the medical needs of veterans, particularly those in areas where access to VA health care is less than optimal.

As to contracting for health care, the hearing record indicated that this option to health care delivery is presently used, well received, and will continue to be used to augment VA health care when access to care or peak workload demands hinder timely health care delivery by VA.

Commission Findings

1. The Far North Market and the North Market have significant gaps for access to hospital care.
2. Inpatient medicine workload is projected to increase in all markets of VISN 1.
3. In-house expansions appear to be a partial and reasonable solution to workload gaps but may not improve access gaps in rural areas.
4. All the VAMCs in this VISN require improvements and enhancements to their physical plants to meet access and workload gaps.
5. VA may be able to partner with the state of Maine to use telemedicine technology.
6. Contracting for care is reasonable to maintain or improve access to health care.

Commission Recommendations

1. The Commission concurs with the DNCP proposal to use contracting to improve access for hospital care in the North and Far North Markets, and to pursue telemedicine opportunities.
2. The Commission recommends that VA ensure that it has quality criteria and procedures for contracting and monitoring service delivery, as well as the availability of trained staff to negotiate cost-effective contracts.

3 The Commission concurs with the DNCP proposal to meet increasing inpatient demand in the East and West markets through in-house expansions at Providence and West Haven. Expansion at West Roxbury should be considered as part of the feasibility study for a replacement facility for Boston.

III Outpatient Care

DNCP Proposals

"*Primary Care/Access* – The DNCP attempts to balance meeting national access guidelines with ensuring the current and future viability of its acute care infrastructure. Because of this, while new access points in this VISN are included in the National Plan, they are not in the high implementation priority category at this time. *Primary Care/ Outpatient Services* – Increasing primary care demand in the Far North, East, and West markets is being met primarily through community contracts, telemedicine, and expansion of existing CBOCs. Some in-house expansion is planned for Brockton, Togus, and Newington. Excess outpatient demand from West Roxbury and from the Causeway Clinic will be moved to Jamaica Plain. *Mental Health* – Increasing demand for mental health in the Far North and North markets is being met through community contracts, telemedicine, and expansion of existing CBOCs that will include mental health services. *Specialty Care* – Increasing specialty care demand in all four markets is being met using community contracts to the extent feasible, telemedicine, shifting selected services to CBOCs and in-house expansion through significant new construction and conversion of vacant space. Northampton will lease 50,000 square feet in the Springfield area. West Roxbury and Providence have replacement operating room projects in their special care expansions."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

CARES workload projections indicate that all markets in VISN 1 will experience increasing demand for primary care and/or specialty care outpatient services creating gaps in the VISN's ability to deliver services. Primary care workload is projected to increase in the West Market by 38 percent over the FY 2001 baseline by FY 2012 and significantly decrease to four percent over the baseline in FY 2022. For specialty care in the West Market, projections indicate an increase 84 percent by FY 2012 and 44 percent by FY 2022.

In the East Market, primary care is projected to increase by 54 percent by FY 2012 and 18 percent by FY 2022. Specialty care for the East Market is projected to increase by 75 percent by FY 2012 and 41 percent by FY 2022.

The North Market will experience significant increases in specialty care of 79 percent by FY 2012 and 56 percent by FY 2022, and only nominal increases in primary care (21 percent by FY 2012, and 0 percent by FY 2022).

The fourth market, Far North, is projected to see a 59 percent increase in primary care by FY 2012 and 28 percent by FY 2022. Specialty care for the Far North is projected to increase by 136 percent by FY 2012 and 104 percent by FY 2022.

Increasing demand for outpatient mental health services is projected in the North and Far North markets, and the levels of projected demand are likely to further increase once the corrected CARES outpatient mental health data is run. The North Market is projected to see a 55 percent increase in demand for outpatient mental health services by FY 2012 and a 17 percent increase by FY 2022.[16]

The Far North Market is of special note. This market is projected to have substantial increases in mental health care by at least 38 percent by FY 2012 and three percent by FY 2022. In addition, the Far North Market is currently below the standard set for access to primary care. Currently only 59 percent of the veterans residing in this largely rural market are within the CARES guidelines set for access to primary care services.[17] The Commission heard testimony regarding access for care in the Far North Market. For example, Mr. John Wallace, representing the Vietnam Veterans of America in that market, provided testimony on the difficulties of accessing care, particularly during harsh Maine winters, when travel is problematic.[18] Mr. Roland La Pointe, Director of the Bureau of Veterans Services for Maine, testified that VA staff conducted Town Hall meetings across Maine and through this collaborative effort a market plan was developed that included new CBOCs in rural areas to improve access, patterned after the successful existing CBOCs in five rural areas of the state.[19]

The DNCP proposes to address this projected demand for services and access by expanding services at existing sites of care, including existing medical centers and CBOCs. Consequently the DNCP does not include any of the VISN's proposed additional CBOCs in the high priority group slated for early activation. The VISN had proposed five new CBOCs, all in the Far North Market. These new CBOCs would be located

[16] Appendix D, *Data Tables*, page D-2.
[17] VISN 1 CARES Planning Initiatives from VISN 1, VA New England Health Care System, submitted April 15, 2003.
[18] John Wallace, State Council President, Vietnam Veterans of America. Transcribed Testimony from the Bedford, MA, Hearing on August 25, 2003, page 84.
[19] Roland La Pointe, Director of the Bureau of Veterans Services for the State of Maine. Transcribed Testimony from the Bedford, MA, Hearing on August 25, 2003, page 117.

across Maine in order to improve access to care and thus address the current deficiencies in access in this market as well as projected needs for increased demand for all types of outpatient care. These CBOCs are also crucial to the VISN's plan to expand inpatient capacity at Togus, by reclaiming old inpatient space that has been converted to outpatient services. Telemedicine is currently being used in the Far North Market in association with Maine's statewide telemedicine program, and would be a valuable adjunct to care at new proposed CBOCs. The proposed new CBOCs would have a relatively smaller staff than an average CBOC and not require the expenditure of large amounts of money to establish. The DNCP proposal to merely expand services at existing sites of care in the Far North Market will not improve access in the market.

The VISN currently provides outpatient services in downtown Boston at the Causeway Clinic, which is located next to a public transportation hub, making it easily accessible for metropolitan area patients. The VISN does not propose to renew the lease on this clinic, but rather proposes to transfer the outpatient services to underutilized space at the Jamaica Plain campus. Staff at the Causeway Clinic acknowledged that this will cause a hardship for many patients since public transportation to Jamaica Plain is much more difficult.

Commission Findings

1. Increases in demand for outpatient services are projected across the VISN.
2. Access to primary care services is well below CARES access standards in the Far North Market.
3. Expansion of services at current sites of care will partially address projected demand for services in the North, West, and East Markets, but will not address access deficiencies in the Far North Market.
4. The VISN's original plan to improve access to care in the Far North Market through deployment of new CBOCs throughout Maine is a well-conceived plan to improve access to care.
5. No new CBOCs are in the DNCP's priority group one for VISN 1.
6. To the extent possible, use of telemedicine and contract care is a reasonable response to access issues, especially in rural areas of Maine.

Commission Recommendations

1. The Commission recommends that:[20]
    a. The Secretary and Under Secretary for Health utilize their authority to establish new CBOCs within the VHA medical appropriations without regard to the three priority groups for CBOCs outlined in the DNCP.

[20] Chapter 3, *National Crosscutting Recommendations: Community-Based Outpatient Clinics (CBOCs)*, contains additional information on this topic.

b VISNs set priorities for the establishment of new CBOCs based on VISN needs to improve access and respond to increases in workload.

c VISNs should be able to address capacity issues, to relieve space deficits at the parent facility, by establishing new sites of care, provided the VISNs have the resources necessary to do so.

d VISNs make efficient use of existing resources, including staffing facilities appropriately to reduce wait times, providing specialty care at CBOCs where appropriate, and providing expanded hours of service at CBOCs to facilitate veteran access to care.

e Whenever feasible, CBOCs provide basic mental health services.

f VISNs collaborate with academic affiliates to develop learning opportunities utilizing CBOCs as teaching sites to enhance quality of care in community-based service settings.

2 The Commission concurs with the DNCP proposal to use telemedicine programs at existing sites of care and at proposed new CBOCs to help address access issues.

3 The Commission recommends that VA ensure that it has quality criteria and procedures for contracting and monitoring service delivery, as well as the availability of trained staff to negotiate cost-effective contracts.

IV Extended Care

DNCP Proposal

"For extended care, the DNCP proposed capital investments to remedy space deficiencies in nursing homes including renovation of 51,289 existing square feet in the West Market (Northampton and West Haven) and the renovation of 43,017 square feet in the Far North Market (Togus)."

DNCP Alternatives

None provided in the DNCP.

Commission Analysis

The Commission heard little specific testimony regarding plans to renovate long-term care space at Northampton, West Haven, and Togus VAMCs. The VISN does seem to have a relatively large complement of nursing home beds.

This VISN may be impacted by the upcoming long-term care model projections. Final decisions regarding any change to the number and location of long-term care beds in VISN 1 need to await the model's projections. However, the Commission recognizes the need to upgrade the environment of care in older VA nursing homes.

Commission Findings

1. Several VISN facilities require some level of upgrade and modernization to inpatient areas.
2. The VISN may be impacted by the upcoming long-term care model projections.

Commission Recommendations

1. The Commission recommends that:[21]
    a. Prior to taking any action to reconfigure or expand LTC capacity or replace existing LTC facilities VA should develop a LTC strategic plan. This plan should be based on well-articulated policies, address access to services, and integrate planning for the LTC of the seriously mentally ill.
    b. An integral part of the strategic plan should be maximizing the use of State Veterans Homes.
    c. Domiciliary care programs should be located as close as feasible to the population they serve.
    d. Freestanding LTC facilities should be permitted as an acceptable care model.

[21] Chapter 3, *National Crosscutting Recommendations: Long-Term Care*, contains additional information on this topic.